

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Primary Residence: _____ City: _____ State: _____ Zip Code _____

GENDER M / F Employed / Student / Other Employer / School Name: _____

Telephone #: _____ Work #: _____ Ext: _____ Cell #: _____

Date of Birth: _____ SS #: _____ Pharmacy # _____

STATUS: Married / Single / Other Primary Dr. Name and phone #: _____

Is this Workers' Comp or MVA? _____ E-MAIL _____

INSURED INFORMATION (If other than patient)

Name: _____ Address: _____

Telephone#: _____ Work/Cell #: _____ Relationship to Patient: _____

Employer Name/Address: _____ Date of Birth : _____ SS#: _____

PRIMARY INSURANCE

Insurance Company: _____ Telephone #: _____

Name of Insured: _____ Relation to Patient : _____

ID #: _____ Group #: _____ Co-Pay: _____

SECONDARY INSURANCE

Insurance Company: _____ Telephone #: _____

Name of Insured: _____ Relationship to Patient: _____

ID#: _____ Group #: _____ Co-Pay: _____

In consideration of services rendered, or to be rendered, I hereby irrevocably assign and transfer to Advanced Orthopaedics, all rights, titles, and interests in the benefits payable for services rendered by Advanced Orthopaedics, provided in the above mentioned policy(ies) of insurance. I hereby authorize the insurance company(ies) herein listed above to pay direct to Advanced Orthopaedics, all benefits due under said policy(ies) by reason of services rendered therein. I will pay Advanced Orthopaedics for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policy (ies). I agree that if my account is referred to an outside agency or attorney for collection, I will be responsible for an additional Collection Fee of fifty dollars (\$50.00) or 20% of the balance owed, whichever amount is greater. A photo static copy of this authorization shall be considered as effective and valid as the original contract.

Patient / Guardian Signature: _____ Date: _____

Date_____

Name_____Age_____Occupation_____

Right handed_____Left handed_____Height_____Weight_____

Are you a New patient?_____ Existing patient?

Who referred you?_____

What is the major problem(s) that you came in for today?_____

What are the symptoms?_____

How long have you had this problem?_____

Has Dr. Rosa/ Dr. Garcia treated you for this problem before? _____ yes _____ no if yes, when_____

Is this the result of an injury? _____ yes _____ no Date of Injury_____

If yes, was it the result of a: please circle

Motor Vehicle Accident___ Work Related___ Fall___ Athletic Injury___ Other_____

Please list any medications (and doses, if known) you are taking for this problem_____

What other treatment have you received for this (physical therapy, surgery, etc)?_____

What tests have you had and when (X-rays, MRI, ct scan)?_____

Are you pregnant? _____ yes _____ no

Are you allergic to any of the following? Please circle Y or N

Y	N	Aspirin	_____allergic reaction	_____gastrointestinal sensitivity
Y	N	Codeine	_____allergic reaction	_____gastrointestinal sensitivity
Y	N	Erythromycin	_____allergic reaction	_____gastrointestinal sensitivity
Y	N	Iodine or Seafood		Y N Sulfa
Y	N	Latex		Y N Tetracycline
Y	N	Lidocaine or Novacaine		Y N X-Ray dye
Y	N	Penicillin (or derivative)		
Y	N	Other	_____	

Do you smoke? Y N How much? _____
If you quit, how long ago? _____

Do you drink alcoholic beverages? Y N

How much? _____social/occasional _____moderate _____heavy

Please list ALL medications that you are now taking (and the dose, if known):

Family History

Y	N	Cancer	Y	N	Heart Attack	Y	N	High Blood Pressure
Y	N	Diabetes	Y	N	Heart Disease (other)	Y	N	Stroke

Other _____

Have you ever been screened or tested for osteoporosis? Y N

If yes, when? _____

Past Medical History

Have you had any of the following diseases of medical problems?

CARDIOVASCULAR

Y N Cardiac disease or heart problem.....if yes, explain _____
Y N Deep venous thrombosis _____
Y N Heart surgery.....if yes, explain _____
Y N Pacemaker Y N Lymphedema
Y N Hypertension

DERMATOLOGIC (skin)

Y N Herpes
Y N Skin cancer

ENDOCRINE

Y N Diabetes
Y N Thyroid disorder (Hypo/Hyper)

GASTROINTESTINAL

Y N Cancer
Y N Gastritis/GI bleed
Y N Ulcer

GENITOURINARY/KIDNEY

Y N Dialysis
Y N Kidney Cancer
Y N Kidney Stones
Y N Renal insufficiency/failure
Y N Ulcerative Colitis
Y N Crohn's Disease

HEENT

Y N Glaucoma

HEMATOLOGIC/BLOOD

Y N Anemia
Y N Bleeding Tendencies
Y N Blood Clotting Abnormalities
Y N Hepatitis A, B, or C

IMMUNOLOGIC

Y N Breast cancer
Y N Chemotherapy
Y N HIV/AIDS
Y N Rheumatoid Arthritis
Y N Systemic Lupus
Y N Radiation Therapy

MUSCULOSKELETAL

Y N Fibromyalgia
Y N Gout
Y N Osteoporosis

NEUROLOGICAL

Y N Seizure disorder
Y N Stroke
Y N Alzheimer's
Y N Parkinson's disease

PSYCHIATRIC HISTORY

Y N Alcohol abuse
Y N Anxiety disorder
Y N Depression
Y N Drug abuse

RESPIRATORY

Y N Asthma
Y N Cancer
Y N COPD (chronic lung disease)
Y N Pulmonary embolism

Other _____

Please list all PREVIOUS
SURGERIES _____

REVIEW OF SYSTEMS

ALLERGIES (other than to medications)

Y N Other
Y N Seasonal

CARDIOVASCULAR

Y N Ankle Swelling
Y N Chest Pain
Y N Heart Palpitations
Y N Murmur
Y N Tightness in chest

CONSTITUTIONAL SYMPTOMS

Y N Dizziness
Y N Fatigue
Y N Fever
Y N Headaches (chronic)
Y N Night sweats

EARS, NOSE, MOUTH, THROAT

Y N Hearing loss
Y N Nose bleeds
Y N Sinus problems
Y N Teeth/gum problems

ENDOCRINE

Y N Cuts take longer to heal
Y N Hyperglycemia
Y N Hypoglycemia
Y N Perimenopausal symptoms

EYES

Y N Cataracts
Y N Vision problems
Y N Glasses/contacts

GASTROINTESTINAL

Y N Abdominal pain
Y N Blood in stool
Y N Heartburn
Y N Hemorrhoids
Y N Ulcer

GENETOURINARY

Y N Blood in urine
Y N Urinary difficulties

HEMATOLOGIC

Y N Anemia
Y N Bleeding problems
Y N Blood clotting problem
Y N Bruise easily

INTEGUUMENTARY

Y N Keloids/hypertrophic scars
Y N Psoriasis
Y N Rash
Y N Ulcerations

MUSCULOSKELTAL

Y N Back, joint, or muscle pain
Y N Weakness

NEUROLOGICAL

Y N Balance problems/dizziness
Y N Neurological symptoms/probl
Y N Seizures
Y N Syncope

PSYCHIATRIC

Y N Addiction to alcohol/drugs
Y N Depression
Y N Psychiatric/emotional difficult

RESPIRATORY

Y N Asthma
Y N Emphysema
Y N Shortness of breath
Y N Sleep apnea
Y N Wheezing

I certify to the best of my knowledge, that the information which I have provided is accurate:

Patient Signature _____

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it

Name: _____ **Birth Date:** _____

Signature: _____

Date: _____

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Richard A. Rosa, M.D., F.A.C.S.
Jason P. Garcia, M.D.

Patient Name: _____

Please take a few moments to fill out the following information for our records:

Please give a phone number where the doctor or staff can reach you with your test results.

Primary #: _____ Secondary #: _____

Patient confidentiality is a prime concern in our office. Please list the names of the person or persons whom we can or cannot speak with regarding your health and well-being and to answer any questions they may have regarding the same.

	Name	Yes	No
Spouse	_____	_____	_____
Children	_____	_____	_____
Other (Significant)	_____	_____	_____

Please specify who the doctor/Physician Assistant/Staff member should call with results if other than yourself:

Name: _____ Relationship to you: _____
Work: _____ Cell: _____

Are you able to receive calls at your workplace? _____

May we state who is calling when calling your workplace? _____

Signature: _____ Date: _____